EXHIBIT 8c

NFL CONCUSSION SETTLEMENT

IN RE: NATIONAL FOOTBALL LEAGUE PLAYERS' CONCUSSION INJURY LITIGATION
No. 2:12-md-02323 (E.D. Pa.)

AUDIT PROCESS HIPAA AUTHORIZATION FORM

This Form authorizes the disclosure of "Protected Health Information" as that term is defined in 45 C.F.R. § 160.103. Protected Health Information includes, but is not limited to, information regarding the Retired NFL Football Player's medical care, treatment, physical or mental condition, and medical expenses. By signing and submitting this Form, I authorize the Medical Provider(s) identified in Section I to release all Protected Health Information regarding my (or the Retired NFL Football Player's, if signed by a Representative Claimant) medical care, treatment, physical and mental condition, and medical expenses, to BrownGreer PLC (250 Rocketts Way Richmond, VA 23231), the Claims Administrator in the *In re: National Football League Players' Concussion Injury Litigation* Settlement Program. These records will be used or disclosed solely in connection with the NFL Concussion Settlement Program involving the Retired NFL Football Player named in Section II.

I. MEDICAL PROVIDER INFORMATION

Provider Name	Andrew Jarminski, MD		
Provider Address	Street: 9161 Sierra Ave.		Suite/Unit: 200B
	City: Fontana	State: CA	Zip: 92335

II. RETIRED NFL FOOTBALL PLAYER

Enter the Retired NFL Football Player's information in this Section II.

Settlement Program ID	260006736			
Player Name	First: [redacted]	M.I.: [redacted]	Last: [redacted]	Suffix:
Social Security Number, Taxpayer ID or Foreign ID Number (if Retired NFL Football Player is not a U.S. Citizen) **of Retired NFL Football Player** (if known)	[redacted] or			
Date of Birth of Retired NFL Football Player	[redacted]			

AUDIT PROCESS HIPAA AUTHORIZATION FORM

III. AUTHORIZATION

By signing below, I acknowledge and understand all of the following:

1.	I have the right to revoke this authorization at any time. If I wish to revoke the authorization, I must do so in writing and must provide my written revocation to the Claims Administrator. The written revocation must be signed and dated. The revocation will not apply to any disclosures that already have been made in reliance on this authorization prior to the date upon which the Claims Administrator receives my written revocation.
2.	My authorization of the disclosure of the subject Retired NFL Football Player's Protected Health Information is voluntary, which means I can refuse to sign this Form. I do not need to sign this Form to obtain health treatment from any medical provider or to enroll in or be eligible for any health plan benefits. However, I recognize that if I do not sign this Form and submit it to the Claims Administrator, my claim(s) may be denied under the terms of the Settlement Agreement.
3.	Any Protected Health Information or other information released to the Claims Administrator may be disclosed to the Special Master, BAP Administrator, Appeals Advisory Panel members, Appeals Advisory Panel Consultants, the Court, Class Counsel, Counsel for the NFL Parties, and the NFL Parties (including the NFL Parties' insurers or reinsurers), may be subject to re-disclosure by such person/entity, and may no longer be protected by applicable federal and state privacy laws. Each of those persons and entities, however, is permitted to use and disclose your information only in accordance with this Form, the Settlement Agreement, a contract executed pursuant to the Settlement Agreement, orders of the Court, and/or applicable law.
4.	My Protected Health Information may include information relating to sexually transmitted disease, acquired immunodeficiency syndrome ("AIDS"), or human immunodeficiency virus ("HIV"), behavioral or mental health services and treatment for alcohol and drug abuse.
5.	This Form is valid from the date of my signature in Section IV until the date that the Claims Administrator performs the last act to process the claim for a Monetary Award that I submitted with this Form.
6.	I have a right to receive and retain a copy of this Form.
7.	Any photostatic copy of this Form shall have the same authority as the original, and may be substituted in its place.

IV. SIGNATURE

The Retired NFL Football Player or Representative Claimant of the Retired NFL Football Player named in Section II must sign and date this Form below. **By signing below, I declare under penalty of perjury, pursuant to 28 U.S.C. § 1746, that all information provided in this HIPAA Authorization Form is true and correct to the best of my knowledge, information and belief.**

Signature	[redacted]	Date	09/04/2017 (Month/Day/Year)
Printed Name	First [redacted]	[redacted]	Last [redacted] Suffix

NFL CONCUSSION SETTLEMENT

IN RE: NATIONAL FOOTBALL LEAGUE PLAYERS' CONCUSSION INJURY LITIGATION
No. 2:12-md-02323 (E.D. Pa.)

AUDIT PROCESS HIPAA AUTHORIZATION FORM

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I. MEDICAL PROVIDER INFORMATION

Provider Name	Venus Paxton, MD		
Provider Address	Street: Sharp Mesa Vista Hospital - 7850 Vista Hill Ave.		Suite/Unit:
	City: San Diego	State: CA	Zip: 92123

II. RETIRED NFL FOOTBALL PLAYER

Enter the Retired NFL Football Player's information in this Section II.

Settlement Program ID	260006736			
Player Name	First: [redacted]	M.I.: [redacted]	Last: [redacted]	Suffix:
Social Security Number, Taxpayer ID or Foreign ID Number (if Retired NFL Football Player is not a U.S. Citizen) **of Retired NFL Football Player** (if known)	[redacted] or _____			
Date of Birth of Retired NFL Football Player	[redacted]			

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3.	Any Protected Health Information or other information released to the Claims Administrator may be disclosed to the Special Master, BAP Administrator, Appeals Advisory Panel members, Appeals Advisory Panel Consultants, the Court, Class Counsel, Counsel for the NFL Parties, and the NFL Parties (including the NFL Parties' insurers or reinsurers), may be subject to re-disclosure by such person/entity, and may no longer be protected by applicable federal and state privacy laws. Each of those persons and entities, however, is permitted to use and disclose your information only in accordance with this Form, the Settlement Agreement, a contract executed pursuant to the Settlement Agreement, orders of the Court, and/or applicable law.
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Signature	[redacted]	**Date**	09/04/2017 (Month/Day/Year)
Printed Name	First [redacted]	Last [redacted]	Suffix

NFL CONCUSSION SETTLEMENT

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No. 2:12-md-02323 (E.D. Pa.)

AUDIT PROCESS HIPAA AUTHORIZATION FORM

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I. MEDICAL PROVIDER INFORMATION

Provider Name	Robert E. Scott, Jr., MD		
Provider Address	Street: 9834 Genessee Ave.		Suite/Unit:
	City: San Diego	State: CA	Zip: 92037

II. RETIRED NFL FOOTBALL PLAYER

Enter the Retired NFL Football Player's information in this Section II.

Settlement Program ID	260006736			
Player Name	First: [redacted]	M.I.: [redacted]	Last: [redacted]	Suffix:
Social Security Number, Taxpayer ID or Foreign ID Number (if Retired NFL Football Player is not a U.S. Citizen) **of Retired NFL Football Player** (if known)	[redacted] or [redacted]			
Date of Birth of Retired NFL Football Player	[redacted]			

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3.	Any Protected Health Information or other information released to the Claims Administrator may be disclosed to the Special Master, BAP Administrator, Appeals Advisory Panel members, Appeals Advisory Panel Consultants, the Court, Class Counsel, Counsel for the NFL Parties, and the NFL Parties (including the NFL Parties' insurers or reinsurers), may be subject to re-disclosure by such person/entity, and may no longer be protected by applicable federal and state privacy laws. Each of those persons and entities, however, is permitted to use and disclose your information only in accordance with this Form, the Settlement Agreement, a contract executed pursuant to the Settlement Agreement, orders of the Court, and/or applicable law.
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Signature	[redacted]	**Date**	09/04/2017 (Month/Day/Year)
Printed Name	First [redacted]	[redacted]	Last [redacted] Suffix

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I. MEDICAL PROVIDER INFORMATION

Provider Name	NFL Total and Permanent Disability Program		
Provider Address	Street: 200 St. Paul Place		Suite/Unit: 2420
	City: Baltimore	State: MD	Zip: 21202

II. RETIRED NFL FOOTBALL PLAYER

Enter the Retired NFL Football Player's information in this Section II.

Settlement Program ID	260006736			
Player Name	First: [redacted]	M.I.: [redacted]	Last: [redacted]	Suffix:
Social Security Number, Taxpayer ID or Foreign ID Number (if Retired NFL Football Player is not a U.S. Citizen) **of Retired NFL Football Player** (if known)	[redacted] or			
Date of Birth of Retired NFL Football Player	[redacted]			

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3.	Any Protected Health Information or other information released to the Claims Administrator may be disclosed to the Special Master, BAP Administrator, Appeals Advisory Panel members, Appeals Advisory Panel Consultants, the Court, Class Counsel, Counsel for the NFL Parties, and the NFL Parties (including the NFL Parties' insurers or reinsurers), may be subject to re-disclosure by such person/entity, and may no longer be protected by applicable federal and state privacy laws. Each of those persons and entities, however, is permitted to use and disclose your information only in accordance with this Form, the Settlement Agreement, a contract executed pursuant to the Settlement Agreement, orders of the Court, and/or applicable law.
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Printed Name	First [redacted]	[redacted]	Last [redacted]	Suffix

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I. MEDICAL PROVIDER INFORMATION

Provider Name	Benjamin Domb, MD		
Provider Address	Street: 1010 Executive Court		Suite/Unit: 250
	City: Westmount	State: IL	Zip: 60599

II. RETIRED NFL FOOTBALL PLAYER

Enter the Retired NFL Football Player's information in this Section II.

Settlement Program ID	260006736			
Player Name	First: [redacted]	M.I.: [redacted]	Last: [redacted]	Suffix:
Social Security Number, Taxpayer ID or Foreign ID Number (if Retired NFL Football Player is not a U.S. Citizen) **of Retired NFL Football Player** (if known)	[redacted] or [redacted]			
Date of Birth of Retired NFL Football Player	[redacted]			

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Printed Name	First [redacted]	Last [redacted]	Suffix